MICRONEEDLING DETAILED CLIENT INFORMATION

FULL NAME:

ADDRESS:

CITY: **STATE:**

ZIP CODE: **DATE OF BIRTH:**

PHONE: **EMAIL:**

EMERGENCY CONTACT NAME: **PHONE NUMBER:**

CONSENT SIGNED: ◯ YES ◯ NO

PREVIOUS MICRO-NEEDLING TREATMENT: ◯ YES **DATE:** _____ ◯ NO

ARE YOU CURRENTLY TAKING ANY MEDICATIONS:

◯ YES _____ ◯ NO

DO YOU BRUISE, BLEED, OR SCAR EASILY?: ◯ YES ◯ NO

ALLERGIES? IF YES, PLEASE LIST: ◯ YES ◯ NO

_____

DO YOU PRESENTLY HAVE OR PREVIOUSLY HAD ANY OF THE FOLLOWING:

◯ YES ◯ NO **HISTORY OF MRSA**
◯ YES ◯ NO **BOTOX**
◯ YES ◯ NO **FOREHEAD/BROW LIFT**
◯ YES ◯ NO **FACE LIFT**
◯ YES ◯ NO **CHEMICAL PEEL**
◯ YES ◯ NO **CURRENTLY PREGNANT**
◯ YES ◯ NO **CURRENTLY BREASTFEEDING**
◯ YES ◯ NO **HEART CONDITION**
◯ YES ◯ NO **AUTOIMMUNE DISORDER**

◯ YES ◯ NO **CANCER**
◯ YES ◯ NO **OILY SKIN**
◯ YES ◯ NO **ACCUTANE OR ACNE TREATMENT**
◯ YES ◯ NO **CHEMOTHERAPY/ RADIATION**
◯ YES ◯ NO **TAN BY BOOTH OR SUN**
◯ YES ◯ NO **TUMORS/ GROWTHS/ CYSTS**
◯ YES ◯ NO **TAKING BLOOD THINNERS SUCH AS: ASPIRINM IBUPROFEN, ALCOHOL, ETC.**
◯ YES ◯ NO **ANY DISEASES OR DISORDERS**
◯ YES ◯ NO **DO YOU USE SKIN CARE PRODUCTS CONTAINING RETIN-A, GLYCOLIC ACID, OR ALPHA HYDROXYL?**

MICRONEEDLING CONSENT FORM

☐ I understand that there are some risks with any procedure and I agree to assume those risks. The following are possible reactions with Micro-needling: temporary bruising, skin discomfort during injections, redness or swelling, lightening or darkening of the skin, itching and burning. Skin infection is a possibility any time an injection or surgical procedure is done. Side effects are most of the time temporary and typically resolve within 3 days. Total healing time depends on the depth of the treatment, skin type, and skin condition, and some patients may heal completely in 24 hours.

☐ I understand this technique involves the introduction of fine needles through the skin. The purpose is to create micro-channels in the skin allowing the infusion of active ingredients (such as vitamin C, hyaluronic acid and others) to penetrate deeply and effectively into the dermis, nourishing the skin and stimulating the regrowth of collagen. A series of 4 to 6 treatments are recommended and the frequency will depend on the intensity and depth of the needle.

☐ I understand that the treatments require many small injections on the area(s) to be treated. I understand that the administration of numbing creams may be used if deemed needed.

☐ I understand that results may not be seen in a single treatment. I am aware that the results achieved by this treatment may vary from person to person. Some patients typically notice an immediate glow, but visible improvement will take about 2-4 weeks and can continue for up to 6 months.

☐ Micro-needling is not suitable in these circumstances: Have used Accutane (isotretinoin) within the last year | Have open wounds, cuts or abrasions on the skin | Have had radiation treatment to the skin within the last year | Have any kind of current skin infection, condition, herpes simplex in the area to be treated. Are pregnant or breast feeding | Have any history of keloid or hypertrophic scars or poor wound healing

☐ This agreement will remain in effect for this procedure and all future procedures conducted by my technician or any other technician conducting business at the salon/spa listed below. I understand that this agreement is binding and that I have read and fully understand all information on this page. I represent that I am over the age of 18 years. If below 18 years of age a parent or guardian must also sign this form.

☐ I release my technician or salon/spa (_____) from all liability associated with this procedure. I will not hold the technician or business performing this service on me responsible in any way for any damages or issues that may arise as a result of having the micro-needling procedure performed on me.

☐ By signing below, I verify that I have read and understand the above statements and agree to them.

Client Signature:

Date: